by March 23, 2010); and not less than 75 percent of the positions attributable to such increase are in a primary care or general surgery residency programs.

(ii) If a hospital receives an increase in the otherwise applicable FTE resident cap under paragraph (n)(1) of this section, and does not use all of that increase in its final (12-month or partial) cost report of the 5-year period beginning July 1, 2011 and ending June 30, 2016, the Medicare contractor will remove the applicable unused slots, and the hospital's increase in the otherwise applicable FTE resident cap received under paragraph (n)(1) of this section will be reduced for portions of cost reporting periods on or after July 1, 2016. The number of applicable unused slots is equal to the difference between the increase in the otherwise applicable FTE resident cap and the applicable slots used. In determining the applicable slots used, the following amounts are added, as relevant:

(A) If a hospital uses the increase in the otherwise applicable FTE resident cap under paragraph (n)(1) of this section to expand an existing program(s), the used slots are equal to the lesser of the number of slots used for an expansion(s) in the fourth 12-month cost report or the final cost report.

(B) If a hospital uses the increase in the otherwise applicable FTE resident cap under paragraph (n)(1) of this section to start a new program(s), the used slots are equal to the number of slots used for a new program(s) in the final cost report.

(C) The portion, if any, of the increase in the otherwise applicable FTE resident cap under paragraph (n)(1) of this section used for cap relief, subject to the requirements in paragraph (n)(2)(i) of this section.

(iii) CMS may determine whether a hospital has met the requirements under paragraphs (n)(2)(i) and (n)(2)(ii) of this section during the 5-year period of July 1, 2011, through June 30, 2016, in such manner and at such time as CMS determines appropriate, including at the end of such 5-year period.

(iv) In a case where the Medicare contractor determines that a hospital did not meet the requirements under paragraphs (n)(2)(i), (n)(2)(ii), and (n)(2)(iii) of this section in a cost reporting period within the 5-year time period, the Medicare contractor will reduce the otherwise applicable FTE resident cap of the hospital by the amount by which such limit was increased under paragraph (n)(1) of this section from the earliest cost reporting period that is reopenable in which it would be determined that the hospital did not meet the requirements.

(o) *Determination of an increase in the FTE resident cap due to slots redistributed from a closed hospital.* (1) Except in the case of the closure of the hospital with Medicare Provider Number 05–0578, in the instance of a hospital closure, as defined at paragraph (h)(1)(i) of this section, the FTE resident cap of the closed hospital would be redistributed, and a hospital that meets the requirements and qualifying criteria of section 1886(h)(4)(H)(vi) of the Act and implementing instructions issued by CMS, including submission of a timely application to CMS, may receive an increase in its FTE resident cap, as determined by CMS.

(2)(i) Except in the case of the closure of the hospital with Medicare Provider Number 05–0578, in redistributing the FTE resident cap of a closed hospital, consideration shall be given to ensure that there is no duplication of FTE slots between FTE slots redistributed under this paragraph and temporary adjustments to FTE resident caps provider under paragraph (h)(2) of this section.

(ii) The provisions of this paragraph (o) will not be applied in a manner that will require the reopening of settled cost reports, except where the provider has a jurisdictionally proper appeal pending on direct GME or IME payments as of March 23, 2010.

[69 FR 49254, Aug. 11, 2004, as amended at 69 FR 60252, Oct. 7, 2004; 69 FR 78530, Dec. 30, 2004; 70 FR 47489, Aug. 12, 2005; 71 FR 18666, Apr. 12, 2006; 71 FR 38266, July 6, 2006; 71 FR 48142, Aug. 18, 2006; 72 FR 66932, Nov. 27, 2007; 73 FR 48756, Aug. 19, 2008; 74 FR 44001, Aug. 27, 2009; 75 FR 72263, Nov. 24, 2010; 76 FR 13524, Mar. 14, 2011; 77 FR 53680, Aug. 31, 2012; 79 FR 50357, Aug. 22, 2014]

§ 413.80 Direct GME payments: Determination of weighting factors for foreign medical graduates.

(a) The weighting factor for a foreign medical graduate is determined under

the provisions of § 413.79 if the foreign medical graduate—

(1) Has passed FMGEMS; or

(2) Before July 1, 1986, received certification from, or passed an examination of, the Educational Committee for Foreign Medical Graduates.

(b) Before July 1, 1986, the weighting factor for a foreign medical graduate is 1.0 times the weight determined under the provisions of § 413.79. On or after July 1, 1986, and before July 1, 1987, the weighting factor for a graduate of a foreign medical school who was in a residency program both before and after July 1, 1986 but who does not meet the requirements set forth in paragraph (a) of this section is .50 times the weight determined under the provisions of § 413.79.

(c) On or after July 1, 1987, these foreign medical graduates are not counted in determining the number of FTE residents.

(d) During the cost reporting period in which a foreign medical graduate passes FMGEMS, the weighting factor for that resident is determined under the provisions of § 413.79 for the part of the cost reporting period beginning with the month the resident passes the test.

(e) On or after September 1, 1989, the National Board of Medical Examiners Examination, Parts I and II, may be substituted for FMGEMS for purposes of the determination made under paragraphs (a) and (d) of this section.

(f) On or after June 1, 1992, the United States Medical Licensing Examination may be substituted for the FMGEMS for purposes of the determination made under paragraphs (a) and (d) of this section. On or after July 1, 1993, only the results of steps I and II of the United States Medical Licensing Examination will be accepted for purposes of making this determination.

[69 FR 49254, Aug. 11, 2004]

§ 413.81 Direct GME payments: Application of community support and redistribution of costs in determining FTE resident counts.

(a) For purposes of determining direct GME payments, the following principles apply:

(1) *Community support.* If the community has undertaken to bear the costs of medical education through community support, the costs are not considered GME costs to the hospital for purposes of Medicare payment.

(2) *Redistribution of costs.* The costs of training residents that constitute a redistribution of costs from an educational institution to the hospital are not considered GME costs to the hospital for purposes of Medicare payment.

(b) *Application.* A hospital must continuously incur costs of direct GME of residents training in a particular program at a training site since the date the residents first began training in that program in order for the hospital to count the FTE residents in accordance with the provisions of §§ 413.78, 413.79 (c) through (e), and 413.79(k). This rule also applies to providers that are paid for direct GME in accordance with § 405.2468 of this chapter, § 422.270 of this subchapter, and § 413.70.

(c)(1) *Effective date.* Subject to the provisions of paragraph (c)(2) of this section, payments made in accordance with determinations made under the provisions of paragraphs (a) and (b) of this section will be effective for portions of cost reporting periods occurring on or after October 1, 2003.

(2) *Applicability for certain hospitals.* With respect to an FTE resident who begins training in a residency program on or before October 1, 2003, and with respect to whom there has been a redistribution of costs or community support determined under the provisions of paragraphs (a) and (b) of this section, the hospital may continue to count the FTE resident until the resident has completed training in that program, or until 3 years after the date the resident began training in that program, whichever comes first.

[69 FR 49254, Aug. 11, 2004]

§ 413.82 Direct GME payments: Special rules for States that formerly had a waiver from Medicare reimbursement principles.

(a) Effective for cost reporting periods beginning on or after January 1, 1986, hospitals in States that, prior to becoming subject to the prospective payment system, had a waiver for the operation of a State reimbursement control system under section 1886(c) of